



South Central District Health

1020 Washington St N \* Twin Falls ID 83301

*Keeping your family & community healthy*

### **Information and Request for Volunteers to Assist Victims of Hurricane Katrina Arriving in Idaho**

An unknown number of evacuees from areas affected by Hurricane Katrina may be sent to Idaho by FEMA in the next few weeks. There is a low likelihood that evacuees will actually be sent to Idaho, but District Health departments are preparing to help just in case. Details of evacuees' arrival are not known, but they may arrive by airplane in multiple groups ranging from 40 to 500 people and would be temporarily housed at Gowen Field in Boise for one week before transfer to available housing in the local community. The health status of these evacuees will not be clearly understood prior to arrival.

The State of Idaho is asking for help from physicians, nurses, pharmacists, and nurse practitioners and physician assistants willing to assist Idaho National Guard Medical Teams in assessment, triage, and treatment of evacuees as they arrive. Licensed Idaho healthcare providers may be needed for three general areas of assistance:

<b>Level of Response</b>	<b>Time Commitment</b>	<b>Skills Desired</b>
Short-term, assessment, triage and stabilization of evacuees arriving at Gowen Field, Boise	Hours	Emergency and acute care, triage, emergency response
Medium-term staffing of acute care facility at Gowen Field, Boise	1 day or several days	Acute care, mental health, general medicine
On-going care for persons requiring a medical "home" for their medical needs	Weekly plus	All skills

Patients arriving as evacuees of the hurricane will have Idaho Medicaid eligibility. Anticipated medical problems include medication needs assessments for chronic health conditions, acute respiratory illnesses, immunization needs, acute non-severe injuries, and mental health concerns.

Volunteers should be licensed to practice in Idaho, and it is recommended that they be current on their diphtheria, tetanus, and hepatitis B immunizations.

**If you would like to be placed on a volunteer list to be contacted as the need arises, please do one of the following:**

- Call South Central District Health to register (737-5908).
- Print off the form on the next page, fill it out and either:
  - fax it to District Health (734-9502)
  - or mail it (1020 Washington St. North, Twin Falls, ID 83301 - Attn: Karyn Goodale).

Volunteer lists are being coordinated by all Health Districts throughout the state. Volunteering does not commit you to any specific activity at this time, but rather provides a contact list for disaster response coordinators.

The federal government is also urgently seeking healthcare volunteers for field work in the South. See <https://volunteer.ccrf.hhs.gov/> for further information on volunteering.



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1020 Washington St N \* Twin Falls ID 83301

Karyn Goodale, MPH – Public Health Preparedness, Manager

For more information, please call 737-5908.  
To respond, fax to 734-9502 or mail to South  
Central District Health, Attn: Karyn Goodale

### IDAHO'S RESPONSE to HURRICANE KATRINA MEDICAL RESERVE CORE Available Emergency Health Care Provider Assessment

Name: \_\_\_\_\_

Name of Current Employer: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Fax \_\_\_\_\_

Work E-mail \_\_\_\_\_ Work Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home E-mail \_\_\_\_\_

I am willing to provide volunteer emergency health care services for victims of Hurricane Katrina:

☐ Yes ☐ No

In the event of other large scale emergencies, such as a natural disaster or a terrorist attack, I am willing to provide volunteer emergency health care services: ☐ Yes ☐ No

Please check type of license	License #	Expiration Date
____ Physician	_____	_____
____ NP / PA	_____	_____
____ RN	_____	_____
____ LPN	_____	_____
____ Pharmacist	_____	_____
____ Other medical license	_____	_____

Please check specialty areas and year of last study or practice in that area:			
	Year of last study/practice		Year of last study/practice
<input type="checkbox"/> Medical	_____	<input type="checkbox"/> Pediatrics	_____
<input type="checkbox"/> Emergency Department	_____	<input type="checkbox"/> General Clinic	_____
<input type="checkbox"/> Triage by History	_____	<input type="checkbox"/> Immunization	_____
<input type="checkbox"/> Triage by Injury	_____		

What language(s) are you fluent in:

Reading

Writing

Speaking

\_\_\_\_\_  
\_\_\_\_\_  
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I understand that submitting this application does not guarantee selection for placement. I understand that the information from this application may be shared with federal, state, regional, or local partners in planning for emergency preparedness and with those agencies where I will be placed as a volunteer. I hereby give my permission for the information provided above to be entered on the Idaho Volunteer Database System. I understand that I have the right to withdraw my application or discontinue my enrollment as a volunteer at any time with written notification to my Health District Volunteer Coordinator.